Testimony on

The Medicare Advantage Program

By

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I. Introduction

Mr. Chairman, Ranking Member Camp, and members of the subcommittee, my name is Daniel Lyons. I am Senior Vice President of Government Programs for Independence Blue Cross, and I appreciate this opportunity to testify about the Medicare Advantage program and its role in providing Medicare beneficiaries with options for high quality, affordable, comprehensive health coverage.

Independence Blue Cross is a non-profit health insurer that serves 3.4 million members, approximately 240,000 of which are Medicare beneficiaries; and is part of the national network of 39 Blue Cross and Blue Shield plans that insure approximately one out of every three Americans. Most of our members are in the greater Philadelphia region, and we are both the region's most preferred health insurer as well as the insurer of last resort. We offer a range of coverage options to Medicare beneficiaries, including HMO plans, point-of-service (POS) plans, PPO plans, Medicare Part D coverage, and supplemental coverage.

Independence Blue Cross is strongly committed to the long-term success of the Medicare Advantage program. We are proud to sponsor plans that offer many services and innovations that are not included in the Medicare fee-for-service (FFS) program. Our Medicare Advantage plans serve a critical role in providing comprehensive, coordinated benefits for many seniors and disabled Americans – including low-income beneficiaries who cannot afford the high out-of-pocket costs they would incur under the Medicare FFS program.

My testimony today will focus on three broad areas:

- the conceptual rationale for why Medicare Advantage plans add value over the Medicare FFS program;

- advances in care coordination and disease management that are significantly improving patient care for beneficiaries enrolled in Medicare Advantage plans; and

- the value the Medicare Advantage program offers beneficiaries, particularly those who need assistance managing their multiple chronic conditions.

II. Why Medicare Advantage Adds Value Not Found in Medicare FFS

The fundamental difference between Medicare Advantage plans and the Medicare FFS program is that the former have established an infrastructure for improving health care quality on an ongoing basis. This is critical, because it is well documented that we have significant shortcomings in the quality of health care under our current system in general and the Medicare program in particular. Over the past decade, the Institute of Medicine (IOM) has focused the nation's attention on the critical need to improve health care quality and patient safety, coordinate chronic care, and support evidence-based medicine. A 1999 IOM report[1] found that medical errors could result in as many as 98,000 deaths annually, and a more recent IOM report acknowledged the fragmented nature of care delivery in the Medicare FFS program, which does "little to encourage coordinated, preventive, and primary care that could save money and produce better health outcomes."[2]

Other studies have documented specific shortfalls in quality. For example, a study conducted by RAND[3] found that patients received only 55 percent of recommended care for their medical conditions, and a study by the Medicare Payment Advisory Commission (MedPAC)[4] showed that only two-thirds of Medicare beneficiaries received necessary care for 20 of 32 indicators. The MedPAC report concluded that "care coordination is more difficult to do in the FFS program because it requires managing patients across settings and over time, neither of which is supported by current payment methods or organizational structure." Additional studies indicate that Americans frequently receive inappropriate care in a variety of settings and for many different medical procedures, tests, and treatments. Such inappropriate care includes the overuse, underuse, or misuse of medical services.

[1] "To Err is Human," Institute of Medicine, 1999
[2] IOM Report: "Rewarding Provider Performance: Aligning Incentives In Medicare," IOM, 9/21/06
[3] "The Quality of Health Care Delivered to Adults in the United States.," Elizabeth A. McGlynn, RAND, June 25, 2003
[4] MedPAC, Report to Congress: Increasing the Value of Medicare, June 2006

Medicare Advantage plans focus on identifying members with important clinical needs, including those not receiving preventive care, those that are frail, and those with chronic illness. Because Medicare Advantage plans have an infrastructure to coordinate and improve care for these members, there is a proven track record of making a positive difference in the lives of Medicare beneficiaries. The 2007 NCQA State of Quality Report[5] documents significant improvements over time in the quality of care for Medicare beneficiaries enrolled in Medicare Advantage plans, and a good example of this is the improvement in care for cardiac patients. In 2006, approximately 94 percent of Medicare beneficiaries in Medicare Advantage plans received a beta-blocker upon discharge from a hospital after having a heart attack. Ten years earlier that number was close to 60 percent. Beta blockers have been proven to save lives if given after a heart attack, so this significant increase in the use of beta blockers is saving lives and the favorable trend for Medicare Advantage members is not matched in the FFS program.

III. Advances in Care Coordination and Disease Management

The participation of private health insurance plans in Medicare has enabled millions of seniors and disabled persons to benefit from chronic care initiatives and other innovations that are improving their health care and enhancing their overall quality of life. Many Medicare beneficiaries suffer from multiple chronic conditions – such as diabetes, heart disease, cancer, asthma, and depression – and one study suggests that over 80 percent of Medicare beneficiaries have at least one chronic condition.[6] Medicare Advantage plans meet a critical need by offering care coordination and management for diseases that commonly afflict the elderly.

Health insurance plans are playing a leadership role in developing strategies and programs to improve patient care for persons with chronic conditions. We are focused not only on ensuring that patients with chronic conditions live longer – but we also are helping them live healthier lives, with fewer symptoms, so they can fully participate in the activities they enjoy. This requires a strong emphasis on preventive care, personal responsibility for healthy lifestyles, and

[5] The State Of Health Care Quality 2007, NCQA, September 2007
[6] Wolff, Starfield and Anderson, "Prevlalence, Exprenditures and Complications of Multiple Chronic Conditions in the Elderly," Archives of Internal Medicine, November 11, 2002

early intervention to promote care strategies that are effective in improving the patient's quality of life.

Health plans have a strong track record of encouraging prevention and evidence-based care for individuals with chronic conditions. We also are working on an ongoing basis to continue to develop new tools and greater expertise to help physicians customize care strategies to meet the unique needs and circumstances of individual patients. Building upon the success of early innovations in disease management, we are taking personalized service to a new level through a new generation of chronic care initiatives. Recent publications by America's Health Insurance Plans (AHIP)[7] and the Blue Cross Blue Shield Association (BCBSA)[8] document numerous examples of health plan programs that provide the frail elderly and others with chronic conditions the care they need. These efforts reflect the following interconnected trends:

- First, plans are using increasingly sophisticated data mining techniques, such as informatics and predictive modeling, to identify high risk members and members with documented gaps in care. The most recent advances in the use of information technology include moving toward personal health records (PHRs) for health plan enrollees – to improve the delivery of care, enhance health care quality, and increase productivity. In November 2006, the Board of Directors of our industry association, AHIP, endorsed a set of recommendations calling for the industry to implement steps to standardize health plan-based PHRs. These recommendations, developed in partnership with BCBSA, will facilitate both information sharing between consumers and caregivers, and portability when a consumer changes health plans.

- Second, plans are proactively reaching out to members who are at high risk, and to their physicians, to offer information, guidance and support on closing gaps in care, increasing the use of preventive care, and improving self-management and provider management of chronic illnesses.

[7] AHIP, *Innovations in Chronic Care*, March 2007
[8] Blue Cross Blue Shield Association, *Medicare Advantage: Improving Care Through Prevention, Coordination, and Management*, February, 2007

- Third, plans are offering health coaching to change patient behavior. Through the use of nurses and other health professionals who are trained to serve as health coaches, we are helping health plan enrollees to better understand their treatment options to make more informed health care decisions; to make lifestyle changes to improve their health; to understand and follow their doctors' treatment plans; and to address other health and social service needs.

- Fourth, plans are recognizing that patients are well served by a comprehensive strategy that addresses the needs of each person as a whole, rather than a narrow approach that targets individual diseases. Accordingly, we are using nurse case managers to identify barriers to effective care (including financial, transportation, or social support issues, and a lack of integration between health care providers) and are helping individuals overcome these barriers and get their care better coordinated.

- Finally, plans are placing a greater focus on prevention, wellness and the continuum of health care services that people need throughout their lives. By providing a full spectrum of services – ranging from wellness and prevention to acute, chronic, and end-of-life care – we are improving health outcomes and addressing the unique needs and circumstances of each individual patient.

The effectiveness of these initiatives was highlighted in a 2007 report[9] by the California Association of Physician Groups (CAPG), which states: "It is the experience of more than 150 physician groups in California and the 59,000 physicians who are part of these groups that they are able to provide better health care to their patients who are in Medicare Advantage plans than those in traditional Medicare." While discussing the specialized services that are needed for patients with chronic conditions, the report states that "these care management services are possible only in the context of the MA program and are virtually non-existent in traditional Medicare."

[9] The Experience of California Physicians in the Medicare Advantage and Traditional Medicare Programs, Executive Summary, California Association of Physician Groups, June 2007

Allow me to provide some examples of the types of programs that are in place at Independence Blue Cross. Our Medicare Advantage members benefit from a variety of programs aimed at improving their care, including the promotion of prevention and wellness. Here are some specifics of these programs:

Our Connections[SM] Health Management program is designed to help our Medicare Advantage members by making them more informed about their health conditions, assisting them in making difficult treatment decisions, helping them and their physicians improve the management of chronic conditions, and assisting members and their physicians with the coordination of care.

- This program is available to all 165,000 of our Medicare Advantage members, and only about 2 percent of these beneficiaries opt out of the program.

- Approximately 70,000 of these members have one or more of five common chronic illnesses: coronary heart disease, congestive heart failure, diabetes, chronic obstructive pulmonary disease, or asthma. An additional 2,600 members have one of 16 less common chronic illnesses such as Parkinson's Disease, rheumatoid arthritis, or seizure disorders; and 500 have end stage renal disease.

- Using sophisticated predictive modeling tools, we identify those members who are at highest risk for future health care events, and identify specific gaps in care. Examples of these gaps in care would include such events as members with congestive heart failure not on appropriate medication therapy, elevated cholesterol levels in members with heart disease, lack of appropriate monitoring of blood sugars in diabetics or blood sugar levels that are too high, or the lack of a prescription for a medication included in evidence-based recommendations for a particular disease or condition.

- Specially trained health coaches, who are typically RNs and are available 24/7, 365 days a year, do telephonic outreach to these members to address their care gaps, and to help them understand their physician's treatment plan and improve self-management of their chronic conditions.

- These health coaches can also provide shared decision-making support for any member facing a number of specific treatment decisions, such as the treatment of low back pain, or the treatment of prostate or breast cancer.

- The physicians caring for these patients receive a comprehensive registry, the SMART™ Registry, that lists each of their patients with a chronic illness, specific gaps in care that exist for each patient, and how that practice's overall performance in the management of chronic disease compares to their peers. In addition, patient-specific "action" sheets are provided to the physician to place in each patient's chart.

- The results of this program are impressive:

  - In our 2007 member satisfaction survey, we found that 94 percent of members were satisfied with their Health Coach assistance and 90 percent were satisfied with their overall program experience. Ninety-four percent said they would recommend the program to others.

  - Moreover, 97 percent of members with chronic conditions indicated that they were able to follow their Health Coach's guidance and nearly 80 percent of these members reported an improved ability to communicate with their health care provider as a result of speaking with a Health Coach. Sixty percent said that speaking with a Heath Coach affected the quality of care they received from their health care provider.

  - Through prevention of complications and relapses of chronic illness, there was a 10 to 15 percent reduction in the use of inpatient hospital days and of professional services such as office visits.

  - Overall medical cost trends came down 1.5 to 2 percent in year one of the program and 3 to 5 percent for year two of the program.

  - There have also been increases in specific quality indicators related to each of the chronic conditions.

Our Medicare Advantage members have enthusiastically embraced wellness programs. At Independence Blue Cross, during 2006 over 9,000 seniors enrolled in our fitness programs, designed to encourage and promote healthy, active lifestyles. Almost 60 percent of these seniors completed the program target of 120 visits per year, double the rate of our non-Medicare members who enrolled in the program.

Another program we have implemented for Medicare Advantage members is our Physician Home Visit program. This program is targeted at keeping home-bound members healthy. These members are some of the most medically frail members we have, but their underlying condition is often a barrier to them keeping appointments for physician visits, and in the absence of timely care their condition deteriorates. Home visits by a physician are an ideal solution, but no longer available to most of our members. Therefore, we identified a group of physicians willing to make "house calls." Our program provides for a physician to conduct a proactive home visit to assess members, and then the physician provides follow up care as needed. This physician also coordinates care with the member's primary care physician and other specialty physicians as needed. While our program only began last year, other health plans have implemented similar programs and seen high levels of member satisfaction, improved control of chronic illnesses, and reduced use of emergency services.

Finally, on an ongoing basis we provide Medicare Advantage members with access to care coordination throughout their health care experience. Examples of this are proactive coordination of post-hospitalization care needs. When a member is scheduled for an elective admission, such as a total knee replacement, we reach out to the member to identify their anticipated post-hospital needs, coordinate with their surgeon, and begin to make arrangements for post-hospital care, such as rehabilitation, before the member actually goes to the hospital. In selected cases, we have identified important pre-operative risks that needed to be resolved before surgery. Upon discharge, we follow up with 48 hours of discharge to make sure the member understands their post-hospital treatment plan and that all necessary care has, in fact, been put in place.

Our programs are carefully selected to meet the local needs of our members, but are similar to those of other health plans. In fact, most Medicare Advantage plans offer these types of valuable services to their members. The latest generation of innovations builds upon the lessons health insurance plans have learned over the past decade about outreach strategies that work, about incentives that encourage healthy lifestyle changes and the use of effective treatments, and about how to track patients' progress in obtaining recommended care. While traditional population-based approaches have offered educational materials and other services to individuals identified as having certain conditions, a growing number of plans are now implementing multi-dimensional programs that offer customized care to reflect the severity of each individual's illness.

For example, an asthma patient who has experienced multiple trips to the emergency room would receive specialized attention, including regular phone consultations with a nurse case manager. Another asthma patient who also suffers from depression would be paired with nurses and social workers who could provide a more intensive level of case management. Yet another asthma patient who takes his medications regularly and has not had any recent emergencies would receive quarterly newsletters and access to a toll-free hotline so he can contact a nurse with questions or concerns.

Through all of these activities, health insurance plans are working on a daily basis to add value to the U.S. health care system and improve patient care for Americans – including Medicare beneficiaries – who have chronic conditions. By promoting healthy behaviors and preventing unnecessary complications and health emergencies, our innovative tools and programs are promoting the best possible use of our nation's health care dollars and enhancing the health, well-being, and productivity of the American people.

IV. The Value of the Medicare Advantage Program

The creation of the Medicare Advantage program, as renamed and revitalized under the Medicare Modernization Act of 2003 (MMA), has provided valuable opportunities for seniors and disabled Americans to benefit from the innovations developed and implemented by private

health insurance plans. Nearly 9 million beneficiaries currently receive high quality coverage through the Medicare Advantage program.

Medicare Advantage plans offer a different approach to health care than beneficiaries experience under the Medicare FFS program. Instead of focusing almost exclusively on treating beneficiaries when they are sick or injured, we also place a strong emphasis on preventive health care services that help to keep beneficiaries healthy, detect diseases at an early stage, and work to avoid preventable illnesses.

The chronic care initiatives outlined in the previous section have special significance for our nation's Medicare beneficiaries. Independence Blue Cross and other Medicare Advantage plans have been at the forefront in offering care coordination and management services that are not available in the Medicare FFS program. The entire scope of private sector strategies – from health coaching to predictive modeling to customized care plans – are an integral part of the value beneficiaries receive through Medicare Advantage. These benefits are particularly important to the frail elderly and others with multiple chronic conditions.

In addition to improving patient care for chronic illnesses, the Medicare Advantage program also provides many additional benefits that are not included in the Medicare FFS benefits package. According to the Centers for Medicare & Medicaid Services (CMS), Medicare Advantage plans are providing enrollees with, on average, savings of almost $90 per month – through improved benefits and lower out-of-pocket costs – compared to what they would pay in the Medicare FFS program. For example:

- **Protection Against Out-Of-Pocket Costs:** Many Medicare Advantage plans provide protection against high annual expenditures to ensure that the most vulnerable beneficiaries are not denied services because they cannot afford the cost-sharing required in the FFS program. In 2008, more than 99 percent of all beneficiaries have access to a plan that has out-of-pocket limits for the year of $5,000 or less and 54 percent of beneficiaries have access to a plan option with out-of-pocket limits for the year of $1,000 or less. Additionally, more than 99 percent of beneficiaries can select a plan with out-of-pocket maximums for inpatient hospital stays.

- **Alternative Cost-Sharing:** Medicare Advantage plans also put preventive benefits and physicians services within reach. Without Medicare Advantage, many beneficiaries would be required to pay 20 percent cost-sharing to go to the doctor or receive a pelvic or prostate exam. Medicare Advantage plans are readily available to almost all Medicare beneficiaries to ensure that cost-sharing is not a barrier to these needed services.

  - While traditional Medicare has a 20 percent co-insurance for primary care visits, many Medicare Advantage plans offer no or low co-payments. Sixty percent of beneficiaries have access to a plan with no cost-sharing for primary care visits, and almost 99 percent of beneficiaries can select a plan with $10 or less as a co-payment for primary care visits.

  - Over 90 percent of all Medicare Advantage plans do not charge cost-sharing for screenings for prostate, pelvic, and breast cancer screenings.

- **Additional Benefits:** Medicare Advantage plans also often provide coverage for benefits not offered by FFS such as preventive eye and hearing exams. About 80 percent of all Medicare Advantage plans offer coverage for these benefits.

In addition, CMS has released findings[10] showing that Medicare Advantage enrollees – when compared to beneficiaries with only FFS coverage – are less likely to report that they have no doctor, less likely to report that they have no usual source of care, and less likely to report that they have trouble getting needed health care services. CMS indicates, based on 2005 data, that:

- 26 percent of beneficiaries with FFS only reported they did not have a usual doctor, compared to only 8 percent of Medicare Advantage enrollees;

- 17 percent of beneficiaries with FFS only said they delayed care because of cost, compared to only 6 percent of Medicare Advantage enrollees; and

[10] CMS, "Medicare Advantage in 2007,".March 2007

- 7 percent of beneficiaries with FFS only said they had trouble getting care, compared to only 3 percent of Medicare Advantage enrollees.

Finally, I want to highlight the findings of a 2007 AHIP survey[11] regarding the important role Medicare Advantage plans play in providing health security to Medicare beneficiaries. According to this survey, 35 percent of Medicare Advantage enrollees – including 62 percent of low-income beneficiaries – said they would skip some of the health care treatments they currently receive if the option of choosing a Medicare Advantage plan was taken away. Another 42 percent said they would pay higher out-of-pocket costs if the option of choosing a Medicare Advantage plan was taken away.

The AHIP survey also found that 90 percent of beneficiaries enrolled in Medicare Advantage are satisfied with their coverage overall. Other findings show that a large majority of beneficiaries are satisfied with the quality of care they receive (93 percent), the number of doctors from which they can choose (92 percent), the benefits they receive (89 percent), the coverage they receive for preventive care (87 percent), their out-of-pocket costs (80 percent), and the coverage they receive for prescription drugs (76 percent).

V. Conclusion

Thank you for considering our perspectives on the Medicare Advantage program. We appreciate this opportunity to testify about the role health insurance plans are playing in providing Medicare beneficiaries with high quality, affordable, comprehensive health coverage. We urge the subcommittee to continue to support adequate funding for the system of competition, choice, and innovation that is delivering savings and value to nearly 9 million Medicare Advantage enrollees.

[11] National Survey Of Seniors Regarding Medicare Advantage, Ayres, McHenry & Associates, Inc. and The Glover Park Group, February 26 - March 2, 2007